Machaon Diagnostics 3023 Summit Street, Oakland, CA 94609 8721 Oak Street, New Orleans, LA 70118	

Lab Result Request

Date(s) of Service: ________________________________

Patient Name: ____________________________________

DOB: ____

Lab Results Requested:

____

I, ____________________________________, have requested copies of my clinical laboratory results from Machaon Diagnostics. In receiving these results, I understand that they should only be interpreted by a qualified physician.

I authorize my results to be released to (if other than self):

Name:____

Relationship to Patient: ____

I authorize my results to be sent via (check one):

☐ Mail (Provide Address):____

____

☐ E-mail (Provide E-mail): ____

I understand that I have the right to revoke this authorization, anytime, by sending a written revocation of authorization to Machaon Diagnostics, 3023 Summit Street, Oakland, California 94609.

The above statements are true and accurate.

Patient Signature: __________________________________ Date: _______________

Parent or Guardian (if under 18): ______________________ Date: _______________

If Applicable Printed Name of Personal Representative: _________________________

Authorization for the Disclosure of Protected Health Information as required by the Health and Accountability Act, 45 C.F.R. Parts 160 and 164.